Clayton Private Practice

105 S. Ellington St. ♦ Clayton, NC 27520
Phone: (919) 243 – 0454 ♦ Fax: (919) 243 – 0923

Authorization To Disclose Health Information

Name: _____ Date of Birth: _____

Information Released To:	**Information Released From:**	
☑ Coach:	Agency:	***Clayton Private Practice***
☐ Physician / Psychiatrist	Address:	105 S. Ellington St. Clayton, NC. 27520
☐ Other(s):	Phone:	Clayton: 919-243-0454
	Fax:	Clayton: 919-243-0923

Reciprocal Authorization for Release of Information (Check if applicable)

☑ I authorize Psychological Mobile Services, P.A. to have continuous dialogue between the personnel of Psychological Mobile Services, P.A. and the individual or group identified above. The individual or group identified above is also hereby authorized to release or share information with Psychological Mobile Services, P.A.

Description of Information to be released

Reason for Disclosure:
☑ Continuity of care / treatment coordination

Specific Information to be disclosed:
☑ Progress reports

- I hereby authorize the release and/or exchange of the above identifying information from my records. I hereby release Psychological Mobile Services, P.A. from all legal responsibility or liability that may arise from this authorization. I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time, except to the extent that Psychological Mobile Services, P.A. has taken reliance upon it. I also understand that such revocation must be in writing and received my provider to be effective.
- I understand that I may refuse to sign this release and that Psychological Mobile Services, P.A. may not condition treatment/services on me signing this form. I understand that information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule. Note: North Carolina law prohibits re-disclosure of any confidential information involving mental health or substance abuse treatment, without the client's permission.
- Please be informed that confidential information may not be released without written consent except in emergency or as provided for in General Statutes 122C-52 through 122C-56.
- Please sign, indicating you have are aware and understand the terms regarding confidentiality, the provision of services is not contingent upon such consent and of the need for such release, the client or legally responsible person shall give consent voluntarily, and that confidential information may not be disclosed without written consent when federal statutes prohibit that release.

This authorization shall remain valid for one year from the date of signature or until: _____

X _____ _____

Member or Guardian Signature) ***Date***